Vol. 5 December 2000

MAINE PRIME CARE UPDATE

# MAINE DEPARTMENT OF HUMAN SERVICES PHARMACY PROGRAMS NEWS

The Maine Medicaid costs for prescription drugs continue to rise, with increases of 20-25% per year. In FY2000, Medicaid spent $165,958,403 for 3,381,970 pharmacy claims. This was an increase of $29,321,021 over FY 1999 and Medicaid is projected to spend $200 million dollars in FY 2001.

The Medicaid population in Maine continues to grow, and now has the largest enrollment in the Program's history. The increasing drug costs can be attributed to rising prices, the discovery of new and better drugs to treat chronic diseases, and development of more high technology drugs.

The Maine Medicaid program covers all drugs of those manufacturers who have signed a rebate agreement with the Health Care Finance Administration (HCFA), so there are very few drugs that are not available to Maine Medicaid recipients. The increased costs can be seen in anti-psychotic medications used to treat mental illness, gastrointestinal drugs / anti-ulcer drugs for stomach disorders, antidepressants to treat depression, and new and better drugs with fewer side effects to treat arthritis.

This does not include the high-technology drugs developed for the treatment of HIV or AIDS, hemophilia, hepatitis and cancer.

It remains a challenge for the Maine Medicaid Pharmacy Programs to provide the best therapies possible for our recipients while attempting to balance and control costs associated with these various treatment options.

Please be looking for the upcoming mailing discussing expansion of the Prior Authorization (PA) program. This is one option we are using to attempt to better control prescription drug costs in the Medicaid Program.

On August 1, 2000 Maine's Drugs for the Elderly or Disabled (DEL) Program was once again expanded. The Basic Component of the Program has been expanded to cover 80% of the cost of prescription drugs from participating manufacturers for all generic drugs. This is in addition to the disease states already covered under the Basic Component. The diseases covered under the Basic Component include Diabetes, Heart disease, High Blood Pressure, Chronic Lung Disease (including emphysema and asthma), Arthritis, Anticoagulation, Hyperlipidemia (high cholesterol), Incontinence, Thyroid Disease, Osteoporosis, Parkinson's Disease, Glaucoma, Multiple Sclerosis / ALS (Lou Gehrig's Disease).

No changes were made in the Supplemental Component that covers all other disease states. Under the Supplemental Component, the participant pays the Medicaid rate less $2 (paid by the State).

An annual catastrophic spending limit was also established for the DEL Program. After the DEL Participant has spent $1000 for prescription drugs in the Program, the State will then pay 80% of the cost of all prescription drugs. However, if the DEL Participant has another prescription drug coverage plan, they must first exhaust that plan's coverage before they can use the DEL card since the DEL Program is the payor of last resort.

*The Pharmacy Programs staff includes: Christine Gee, Director of Pharmacy Programs; Paula Knight, Pharmacist who handles the DEL Program and coordinates the HIV Waiver Program; Susan Curtis, Medical Care Coordinator and Jan Yorks, Medical Care Coordinator. You may reach Christine at 287-4018, Paula at 287-3941, Sue at 287-1818 and Jan at 287-2376. The Pharmacy Programs fax number is (207) 287-8601. Please feel free to contact us at anytime with questions or concerns you may have about the Pharmacy Programs. We welcome your input.*

Maine Department of Human Services
Kevin W. Concannon, Commissioner
Bureau of Medical Services
Quality Improvement Division
1 V.A. Center
Building 205, Third Floor
11 State House Station
Augusta, Maine 04333
1-800-566-3818
TTY / TDD 800-423-4331
*To receive this newsletter by mail contact Faye Patterson at 207-287-4827*
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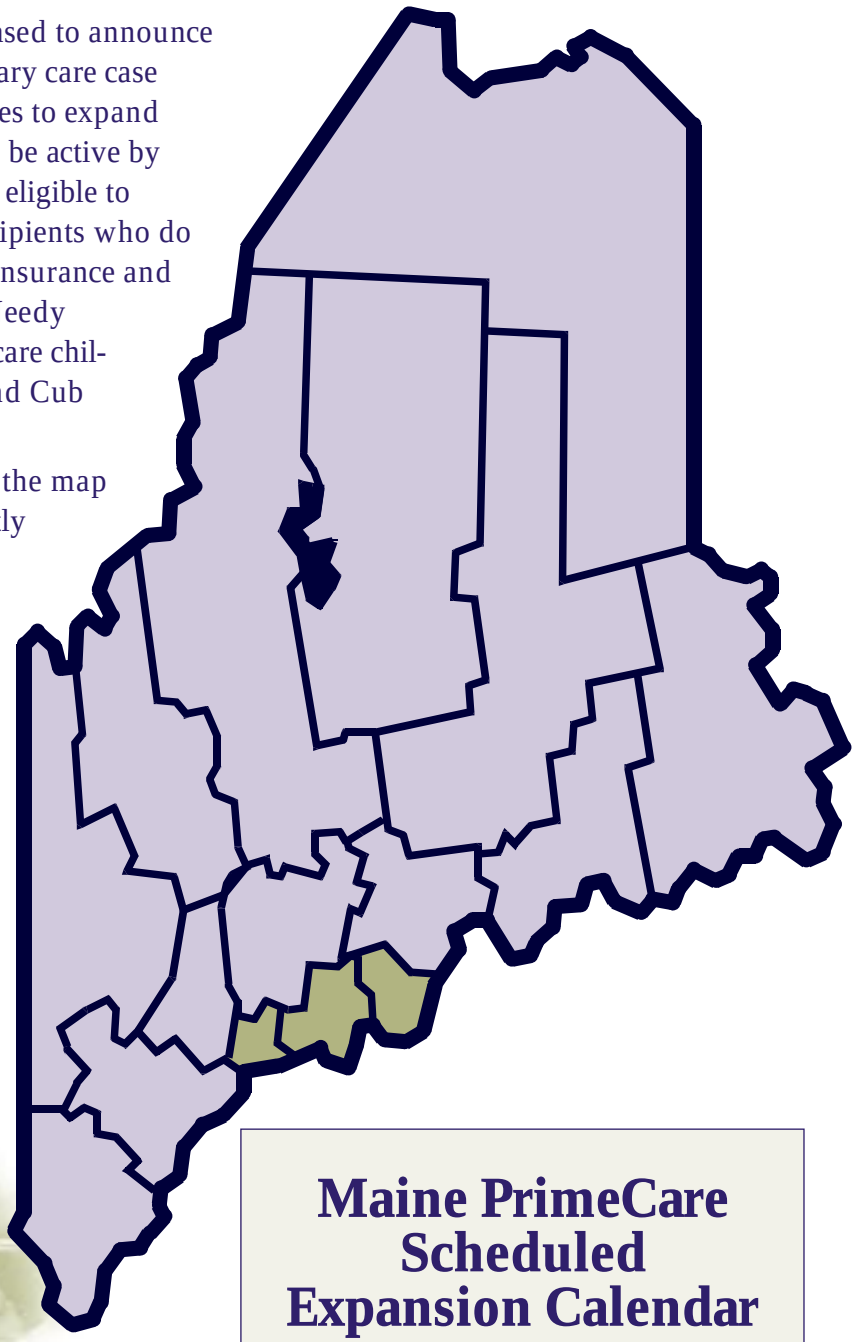
# Maine PrimeCare Expansion Scheduled to be Complete By Year's End

The Bureau of Medical Services is pleased to announce that Maine PrimeCare (Medicaid's primary care case management program - PCCM) continues to expand Statewide with all counties scheduled to be active by December 31, 2000. Medicaid recipients eligible to enroll in the mandatory program are recipients who do not have private comprehensive health insurance and who receive TANF (Temporary Aid to Needy Families), TANF related benefits, foster care children who also receive TANF benefits, and Cub Care recipients.

As indicated by the lavender areas on the map shown here, Maine PrimeCare is currently active in the following counties: Androscoggin, Aroostook, Cumberland, Franklin, Hancock, Kennebec, Oxford, Penobscot, Piscataquis, Somerset, Waldo, Washington, and York.

The remaining green areas indicate the Mid-Coast counties in which Maine PrimeCare will be active by the end of the year.



## Maine PrimeCare Scheduled Expansion Calendar

| | |
|---|---|
| Knox | Mid-October 2000 |
| Lincoln | Early November 2000 |
| Sagadahoc | Mid-December 2000 |

# Maine Medicaid & Maine PrimeCare Managed Care Enrollments By County

| *as of 11/1/00* COUNTY | # of Medicaid Eligible | # of Managed Care Eligible | % of Medicaid Population | # of Maine PrimeCare Enrolled | % of Eligible Population |
|---|---|---|---|---|---|
| Androscoggin | 16,816 | 7,969 | 47% | 7,276 | 91% |
| Aroostook | 15,567 | 7,137 | 46% | 6,789 | 95% |
| Cumberland | 27,301 | 13,389 | 49% | 12,125 | 91% |
| Franklin | 5,036 | 2,690 | 53% | 681 | 25% |
| Hancock | 6,058 | 2,861 | 47% | 2,602 | 91% |
| Kennebec | 17,681 | 8,635 | 49% | 8,123 | 94% |
| Knox | 4,976 | 2,522 | 51% | 1 | 0% |
| Lincoln | 3,900 | 2,103 | 54% | 2 | 0% |
| Oxford | 9,837 | 5,329 | 54% | 4,767 | 89% |
| Penobscot | 23,310 | 11,726 | 50% | 11,014 | 94% |
| Piscataquis | 3,281 | 1,631 | 50% | 1,554 | 95% |
| Sagadahoc | 3,584 | 1,938 | 54% | 5 | 0% |
| Somerset | 10,662 | 5,561 | 52% | 5,309 | 95% |
| Waldo | 6,138 | 3,241 | 53% | 7 | 0% |
| Washington | 8,109 | 4,182 | 52% | 3,997 | 96% |
| York | 19,537 | 9,846 | 50% | 8,918 | 91% |
| Totals | 181,793 | 90,760 | 50% | 73,170 | 81% |

# The Latest on Lead Testing in Maine

The Bureau of Medical Services considers lead testing to be an integral part of the preventive health exam for children. A recent study done by the State's Bureau of Health indicates the incidence of lead testing in the State of Maine to be very low.

To underscore the importance of lead testing for children and increase the incidence of blood lead screening, the Bureau of Medical Services requires that lead testing be done in accordance with the guidelines specified in the Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents. The Bright Futures Guidelines, as many of you know, is the standard Medicaid has adopted for all preventive health exams.

Below is an excerpt from Appendix E of the Bright Futures guidelines providing guidance for lead toxicity screening. This information was obtained from U.S. Department of Human Services, Public Health Service, Centers for Disease Control. 1991. *Preventing Lead Poisoning in Young Children: A Statement by the Centers for Disease Control.* 10/91. N.p.: Centers for Disease Control.

## *Lead Toxicity Screening for Medicaid-Eligible Children*

All children ages 6-72 months of age are considered at risk for lead poisoning and must be screened. A blood lead test must be used to screen Medicaid-eligible children for lead poisoning. *Perform the blood test(s) once between the ages of 6 months and 12 months, and again at 2 years.* Beginning at six months of age, a verbal risk assessment must be performed at every visit. At a minimum, the following questions must be asked:

- ***Does your child live in or regularly visit a house built before 1960? Was his or her child care center/ preschool/babysitter's home built before 1960? Does the house have peeling or chipping paint?***
- ***Does your child live in a house built before 1960 with recent, ongoing, or planned renovation or remodeling?***
- ***Have any of your children or their playmates had lead poisoning?***
- ***Does your child frequently come in contact with an adult who works with lead? (Examples are construction, welding, pottery, or other trades practiced in your community.)***
- ***Does your child live near a lead smelter, battery recycling plant, or other industry likely to release lead? (Give examples in your community.)***
- ***Do you give your child any home or folk remedies that may contain lead?***
- ***Does your child live near a heavily traveled major highway where soil and dust may be contaminated with lead?***
- ***Does your home's plumbing have lead pipes or copper with lead solder joints?***

✒**If the answers to all questions are negative, a child is considered at low risk for high doses of lead exposure but must receive a blood lead test at 12 months and 24 months of age.**

✒**If the answer to any question is positive, a child is considered at high risk for high doses of lead exposure and a blood lead test must be obtained immediately.**

✒**If the initial blood lead test results are < 10 µg/dL, the child must have a screening blood lead test at every visit prescribed in the state's EPSDT periodicity through 72 months of age, unless the child has already received a blood lead test within the six months preceding the periodic visit.**

✒**If a child is found to have blood lead levels > 10 µg/dl, providers are to use their professional judgment with reference to CDC guidelines covering patient management and treatment, including follow-up blood tests."**

To ensure that all Medicaid children receive this screening, please provide documentation of the blood lead screening test on the appropriate well child health assessment forms (BF19). If the Bureau of Medical Services receives a BF19 form, (the 12 month form and/or 24 month form) that does not indicate that a blood lead test was performed, we will contact your office to remind you that this is required for all Medicaid patients and request that you submit documentation of the test.

If you have any questions, please contact HealthWorks by phone @ 1-800-867-4775, by fax @ 1-800-437-5743 or address in writing to the Department of Human Service, Bureau of Health, EPSDT Program, 2 Bangor Street, Augusta, Maine 04333.

## Blood Lead Screening Rates

Medicaid Lead Testing rates among FP/GPs and Pediatricians, 4/1/99–3/31/00.

| Rank | Family Practice/GP | Age One | % with 1+ Test |
|---|---|---|---|
| 1 | Laurie C. Churchill | 16 | 56.3% |
| 2 | Paul J. Jones | 16 | 56.3% |
| 3 | Kevin I. Davey | 13 | 53.8% |
| 4 | Christopher T. Bartlett | 17 | 52.9% |
| 5 | D. L. Jeannotte | 16 | 50.0% |
| 6 | Noah Nesin | 27 | 48.1% |
| 7 | Eugene Paluso | 14 | 42.9% |
| 8 | Gust S. Stringos | 21 | 42.9% |
| 9 | Charles H. Burns | 12 | 41.7% |
| 10 | Timothy Thebald | 15 | 40.0% |

| Rank | Family Practice/GP | Age Two | % with 1+ Test |
|---|---|---|---|
| 1 | Philip H. McFarlane | 10 | 50.0% |
| 2 | Noah Nesin | 11 | 38.4% |
| 3 | Donald G. Brushett | 23 | 34.8% |
| 4 | Merrill R. Farrand Jr. | 12 | 33.3% |
| 5 | Gust S. Stringos | 12 | 33.3% |
| 6 | Michael Lambke | 15 | 26.7% |
| 7 | Barbara A. Vereault | 12 | 25.4% |
| 8 | A. Dorney | 19 | 21.1% |
| 9 | Mark Rolerson | 10 | 20.0% |
| 10 | Deborah Learson | 10 | 20.0% |

| Rank | Pediatrics | Age One | % with 1+ Test |
|---|---|---|---|
| 1 | William T. Whitney | 31 | 83.9% |
| 2 | Ann P. Simmons | 26 | 80.9% |
| 3 | Lori Eckerstorfer | 25 | 80.0% |
| 4 | J.P. DeJohn | 10 | 70.0% |
| 5 | Maria S. J. Noval | 16 | 68.8% |
| 6 | Gautam S.S. Popli | 43 | 67.4% |
| 7 | Valarie M. O'Hara | 17 | 64.7% |
| 8 | Kathleen Hickey | 72 | 61.1% |
| 9 | Iris Silverstein | 42 | 59.5% |
| 10 | Lila H. Monahan | 79 | 59.5% |

| Rank | Pediatrics | Age Two | % with 1+ Test |
|---|---|---|---|
| 1 | Ann P. Simmons | 25 | 56.0% |
| 2 | Lila H. Monahan | 43 | 55.8% |
| 3 | Rosalinda Maraya | 37 | 54.1% |
| 4 | John Hickey | 60 | 53.3% |
| 5 | Iris Silverstein | 29 | 48.3% |
| 6 | Michael P. Hoffman | 52 | 48.1% |
| 7 | Kathleen Hickey | 42 | 47.6% |
| 8 | H Burtt Richardson | 26 | 46.2% |
| 9 | Gautam S.S. Popli | 23 | 43.5% |
| 10 | Jeffery Stone | 58 | 41.4% |

# Helpful Hints From The Prior Authorization Unit About Dental Services Claims Processing

The Prior Authorization Unit has noted in increase in providers requesting prior authorization for dental services. Many of the requests are for procedures that do not require prior authorization, have incorrect procedure codes or require supporting documentation from an attending physician. The Main Medical Assistance Manual (MMAM) lists covered and non-covered services by procedure code under Chapter III, section 60.

In addition, the Prior Authorization Unit would like to pass on some hints to help process claims in a more timely manner:

- Please ensure the Yes/No box on the request form for dentures is checked.
- If requesting replacement dentures please indicate that the request is for replacement and the length of time the recipient had the original dentures.
- Please be sure to supply all the medical necessity documentation with the request for dentures.
- If the request for denture replacement is for an adult, the following information must be supplied:
  1. Any medical condition that is adversely affected by the client not having dentures. (If diabetic, we must have the results of their Hemoglobin A1c testing.)
  2. Weight loss, if directly related from the lack of dentures. Please specify the amount of weight lost and the time period weight loss occurred.
  3. Whether the dentures are replacements or originals, and, when replacements, the disposition of the original dentures.

The Prior Authorization Unit would like to thank providers who include all of this information when the request for authorization is made. By including this information The PA unit can immediately review and make the decisions needed. However when this information is not included with the request the process is dramatically slowed down as staff waste valuable time attempting to track down the information.

## Syrup of What?

*Last winter, the Bureau of Medical Services sent out a survey regarding quality of medical care for children 0-50 months of age to a random sample of Medicaid recipients. One of the most surprising findings from survey data was that many of these parents either didn't have or didn't even know about Ipecac syrup.*

*It seems that there is always room for education and reminders and this would be a good one for our recipients.*

# Update on Q.I. Division's Nursing Facility Immunization Activities

In a November 22, 2000 letter to all Medicaid Directors, HCFA has recommended promoting immunization standing orders to ensure that all nursing facility residents are assessed for and offered influenza and pneumococcal vaccinations.

The Quality Improvement Division continues to work toward improving Pneumonia and Influenza vaccination rates in nursing facilities. A goal of improving the overall immunization rates by 10% has been set for the 2000-2001 Flu season.

In an effort to assist nursing facilities in gathering residents immunization data, we have developed a database to track immunizations. The immunization information obtained from facilities during the 1999-2000 Flu season was entered into the system. Staff have obtained current inpatient status for each licensed nursing facility from the MDS plus system. This information was compared to the immunization information and formatted.

Each licensed nursing home received a resident roster with the residents' pneumonia and influenza status (if known) in September. Under Chapter II, Section 65.05-20, nursing facilities are required to determine each residents pneumonia and influenza status annually, offer immunizations if needed and report the findings to the Bureau in the designated format. The roster list provided to the nursing facilities in September serves as the Bureau's designated tool.

It has been noted that a number of facilities are not completing the form. The three most common errors include failure to provide the pneumonia immunization data, providing the data of 1999 influenza immunizations instead of the 2000 data, and/or failing to note if recipients refused, were allergic or were previously immunized. By not completing the information on each resident the individual facilities immunization rate may be calculated incorrectly. We hope to include a list of the top 10 providers who immunized for pneumonia and influenza in the next two newsletters.

The QI Division would also like to inform nursing facilities that this year the QI staff will not go into the field to obtain data from non-compliant facilities. Facilities who fail to comply with the Medicaid rule will be forwarded to the SURs unit for review. Should a facility have questions or need additional time due to vaccine shortages please feel free to contact Jean Lloyd RN at 287-1068.

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*More Nursing Facility News*

## A Report From The Case Mix/Classification Review Unit

The Case Mix/Classification Review Unit is responsible for the ongoing monitoring of the combined Medicaid/Medicare Reimbursement and Quality Assurance System throughout the state of Maine.

The Health Care Financing Administration (HCFA) mandates the use of a standardized, universal assessment tool (Minimum Data Set 2.0) for all long-term care Nursing Facility residents. The Minimum Data Set is the basis for Case Mix payment and Quality Indicators in Nursing Facilities.

The Case Mix Unit is also responsible for the ongoing development, implementation and education of a case mix system for Level II Cost Reimbursed Assisted Living Facilities. (The goal is for Case Mix payment to be implemented in January 2001.)

Registered Nurses visit all Nursing Facilities and Level II Assisted Living Facilities to review the accuracy of the assessment data.

The Classification Review Unit serves as the technical Help Desk for all the Nursing Facilities and Home Health Agencies. The Unit has become the direct line of communication for problem solving and assistance for all facets of the data submission process.

This unit is also responsible for other Medicaid programs, i.e., Katy Beckett, PDN and Hospice.

**ONGOING:** Case Mix Nurse Auditors continue to offer monthly MDS 2.0 training sessions to Nursing Facilities and MDS-RCA training sessions to the Residential Care Facilities in each of their geographic districts.

Residential Care Clinical Work and Payment Group meetings continue. These sessions are held to gather information and suggestions for upcoming changes to the reimbursement and clinical assessment methods.

**NEW:** Our state has always been and continues to be in the forefront of the MDS world. A committee has been meeting since August 1999 to develop Short Stay Quality Indicators. Short stay is defined as a resident who is admitted and discharged in under 30 days. Training was held in September 2000 for providers on the use of these new reports.

# Pediatric Preventive Care Project

## *Maine Health Research Institute ImmPact Contact Reporting Project*

Immpact is a large and complex database-driven application available over the Internet. It is used by the State of Maine Bureau of Medical Services (BMS), the Bureau of Health (BOH), the Public Consulting Group (PCG) and individual health care providers to keep track of immunizations, Bright Futures well-child visits and contacts with or about patients, among other things.

At this point in time, Immpact has limited reporting capabilities. The Maine Health Research Institute (MHRI) has become involved in order to expand these capabilities in the area of patient follow-up contact. This project is an extension of the work that MHRI has done around Bright Futures Forms. The audiences for the reports are BMS and the health care providers, consequently the specific goals for the project lie in meeting the needs of these two groups.

The first goal is to provide feedback to BMS so that they can monitor the follow-up process and evaluate specific follow-up requests by a provider or for a patient. This aspect of the report will be presented in a web-based format that provides varying levels of detail, from high-level summary statistics to individual reports for a patient or provider.

The second goal is to give feedback to providers so that they can view details about the follow-up they request, and follow-up that is requested for or by their patients. This portion of the report will likely be paper-based and sent to the provider. It will give information about their patients and summary information of comparable providers. Reports for both BMS and providers will present information in such a way as to allow comparisons across time, geographic area, provider type, and provider specialty, among others.

Requests for follow-up services can be initiated either by BMS, by the provider, or by the client themselves. We will look at who is initiating the follow-up, methods used to contact clients, amount of follow-up being done, and why the contacts are made. As part of determining who is initiating the follow-up contacts, we will look at follow-up requested as part of a Bright Futures visit or as part of the Bright Futures form evaluation.

Something that may not be widely known is that a provider can request from BMS a follow-up contact or other assistance for a patient by checking the "EPSDT only: Child needs assistance..." box in the lower right corner of the Bright Futures form.

While the reporting tool being developed by MHRI is still in the design stages, we work with the goal of presenting information in such a way as to assist all involved with Medicaid in providing high levels of care. We invite interested providers to send us your thoughts regarding the type of information you would find useful in the reports. Please send your suggestions via email to jeff.williams@state.me.us.

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# BMS Decides to End Aetna US Healthcare Family Plan

Due to the overwhelming success of Maine PrimeCare, the Bureau of Medical Services will no longer be contracting with Aetna US Healthcare. The Bureau of Medical Services and Aetna US HealthCare have decided to phase out the Aetna FamilyCare program, which currently has only 1800 enrollees. The Aetna FamilyCare Plan has been offered as a voluntary program for Medicaid recipients in Androscoggin, Cumberland, Knox, Lincoln, Sagadahoc, Waldo and York counties.

All Aetna U.S. Healthcare FamilyCare Plan members will be transitioning into Medicaid fee for service beginning November 25, 2000. Aetna referrals will no longer be needed for dates of service after November 24, 2000. Throughout December and January, Aetna patients will be contacted to join Maine PrimeCare. Please be certain to check the Automated Voice Response System at 1-800-452-4694 to determine when Aetna patients have joined Maine PrimeCare. It is always a good idea to check Voice Response for any Medicaid patient that you see for eligibility and Maine PrimeCare enrollment information. All efforts will be made to enroll Aetna U.S. Healthcare FamilyCare members with the same primary care provider in Maine PrimeCare. We hope that this will be a smooth transition for you and your patients.

If you have any questions about Medicaid policy or billing, please call your Provider Relations Specialist at 1-800-321-5557, Option 1. If you have any questions about the Maine PrimeCare Program, please call HealthWorks at 1-800-977-6740, Option 3.

We would like to take this opportunity to thank you for your ongoing support of the Maine PrimeCare Program.

# Quality Improvement's Pain Management Referral Program

The Department of Human Services, Quality Improvement Division has begun a program to assist providers in managing narcotic overuse in recipients with chronic pain. The goals of this project are to improve pain management for recipients with chronic diseases, and to identify recipients that are at risk for over dosage due to elevated use of narcotics.

Many providers have received a copy of the PDDI report over the last several months. This report lists patients for which the provider has prescribed narcotics and that have met any of the following criteria:

- *Have had three or more different schedule III prescriptions within the last 3 months.*
- *Have filled the prescriptions at 3 or more pharmacies or*
- *Have had prescriptions for narcotics from 3 or more different providers.*
- *Have received over 90 days' supply of narcotics in a 90 day period.*

In September a Pain Management Referral form was included with the PDDI mailing. It is the Bureau's hope that providers will make referrals to the Quality Improvement Division after reviewing the PDDI report and recipient records. The Referral form is a one page forms that identifies behaviors which commonly occur in recipients with drug seeking behaviors. Providers are requested to check the boxes next to the statements that apply to the individual recipient and either fax or mail the referral. In addition, the referral form asks providers if they are willing to be the primary prescriber for this recipient.

Once a recipient is referred to the QI Division, a letter is sent to the recipient requesting voluntary enrollment into the program. If the recipient agrees to enroll in the program than the provider is notified and an edit is placed into the pharmacy data system designating the provider as the primary provider. In situations were recipients do not voluntary agree to participate, a review of the recipients claims and medical history is conducted. If through the course of the review the resident is found to be at risk for schedule II abuse, then a referral is made to the Pharmacy review committee. The pharmacy committee has the authority to recommend the recipient to the restriction program for narcotic use. This process assigns a primary prescriber of the residents choice and limits the access of pharmaceuticals to one provider.

In addition to limiting the recipient to one prescriber, the QI Division will be assisting the recipient locate a primary perscriber, providing education, monitoring drug usage, and assisting the provider and recipient upon request.

The upcoming PA Update will provide information regarding how Oxycontin will be affected.



# The Latest News on the FACCT Survey

Over the last 6 months the Bureau of Medical Services, Quality Improvement Division has participated in a survey of Maine Medicaid Recipients ages 0 to 4 years old. This original survey was designed to obtain feedback from Parents/guardians of Medicaid Recipients 0 to 4 years old regarding the quality of services and treatment received.

In an attempt to view the overall system of health care for these recipients, surveys were mailed to providers in September. These surveys were sent to providers who may have provided services to recipients within the original survey group. We are hoping to compare the survey responses received from providers to that received from recipients. In addition, the Quality Improvement Division will compare the survey information to the Bright Future Assessment information to obtain a full picture of the Medicaid Program.

The Quality Improvement Division is hopeful that this information will provide the Bureau with information on educational needs for recipients/ providers, and will help identify areas where services within Medicaid can be improved. We request that any provider who received this survey complete and return it in the self-addressed envelope. The Quality Improvement Division looks forward to reporting the results of the project to providers in the next newsletter.